

Before the
Administrative Hearing Commission
State of Missouri



NEW TRAILS, LLC,)	
)	
Petitioner,)	
)	
vs.)	No. 13-0939 SP
)	
DEPARTMENT OF SOCIAL SERVICES,)	
MISSOURI MEDICAID AUDIT AND)	
COMPLIANCE UNIT,)	
)	
Respondent.)	

DECISION

The petitioner, New Trails, LLC (“New Trails”), a Missouri Medicaid provider, is subject to the sanction of recoupment in the amount of \$1,226.04 because it submitted false claims for payment to the Department of Social Services (“the Department”).

Procedure

New Trails filed two complaints on April 25, 2013, challenging the Department’s imposition of the sanction of recoupment against it for certain violations with which it was charged after a post-payment review. We opened cases 13-0666 SP and 13-0939 SP. The Department filed an answer in both cases on May 30, 2013.

We convened a consolidated hearing in cases 13-0666 SP and 13-0939 SP on December 20, 2013. New Trails was represented by David Barrett. The Department was represented by Assistant Attorney General Matthew Laudano.

On February 10, 2014, New Trails filed its waiver of the requirement found in § 208.221¹ that we render our decision in this matter within 300 days of New Trails filing its complaint.

The case became ready for our decision on June 11, 2014, the date the last written argument was filed. Commissioner Karen A. Winn, having read and personally considered the portions of the record cited or referred to in the parties' written arguments, renders the decision. Section 536.080.2; *Angelos v. State Bd. of Regis'n for the Healing Arts*, 90 S.W.3d 189 (Mo. App. S.D. 2002).

Findings of Fact

1. New Trails is a MO HealthNet provider participating in the Home and Community-Based Services Developmental Disabilities Waiver program administered in part by the Missouri Department of Mental Health ("DMH"). It operates several group homes at which it provides residential habilitation services to developmentally disabled individuals. Two of those group homes are the 9th Street home, the one at issue in this case, and the Stanberry home, at issue in case no. 13-0666 SP.

2. On June 28, 2010, Rick Smith, the administrator and one of the owners of New Trails, executed a contract with DMH whereby New Trails agreed to provide residential habilitation services to DMH clients for reimbursement between July 1, 2010 and June 30, 2013 ("the DMH agreement"). The DMH agreement contained, among other things, the service requirements, billing codes, provider credentialing requirements, and other terms and conditions under which New Trails agreed to provide and be compensated for the services provided under the agreement.

3. Section 5.3.2 of the DMH agreement states:

The contractor shall not be reimbursed for days the consumer is not present. The contractor's allowable monthly costs shall be

¹Statutory references are to RSMo 2000 unless otherwise noted.

redistributed across the days the consumer was present to produce an adjusted payment per day, up to the Medicaid maximum allowable per diem amount.

Resp. Ex. C at 21.

4. New Trails also has a Title XIX participation agreement with the Department (“the Title XIX agreement”). Under the Title XIX agreement, New Trails agrees that will comply with the Medicaid rules and regulations “in the delivery of services and merchandise and in submitting claims for payment,” and that if it does not comply it is not eligible for reimbursement. Resp. Ex. B at 3-4.

5. The Department reimburses New Trails for its services to DMH clients through its MO HealthNet Division (“MO HealthNet”) and carries on an audit function through its Missouri Medicaid Audit and Compliance Unit (“MMAC”).

Post-Payment Review of 9th Street Home

6. On July 9, 2012, Debra Henley, a Medicaid Specialist with MMAC, conducted an on-site, post-payment review of New Trails’ Medicaid claims for the Stanberry and 9th Street group homes. For 9th Street, she requested records pertaining to three residents, L.M., M.M., and K.S.

7. From the records collected pertaining to residents at the 9th Street home, Henley determined that the three residents were absent from the facility for several days during the period from October 1, 2011 through December 31, 2011 (“the audit period”). Resident L.M. was absent November 24, and December 23 and 25, 2011; M.M. was absent December 3 and December 9; and K.S. was absent October 21 and 22 and December 23, 24, and 25. However, New Trails billed MO HealthNet for services to those residents on those dates.

8. Based on these absences, Henley calculated that New Trails was overpaid by \$1,759.84.

9. On April 10, 2010, the Department sent New Trails its final decision notifying New Trails that it had been overpaid in the amount of \$1,759.84 for services incorrectly billed residents of the 9th Street home. The Department imposed the sanction of recoupment for the full amount of the alleged overpayment.

10. The day before the hearing, the Department lowered its recoupment demand by \$533.80. This action was based on Henley's further review of the documents and her subsequent determination that the overpayment letter did not specify that L.M. was actually present at the 9th Street home for part of the day on December 23, 2011 and K.S. was actually present for part of October 21 and December 23, 2011. Tr. 146.

Conclusions of Law

We have jurisdiction over this matter. Sections 208.156.5 and 621.055.1. New Trails has the burden of proof. Section 621.055.1. We decide whether New Trails is liable for an overpayment or sanction and, if so, the amount of the overpayment or the appropriate sanction. We decide the issues *de novo*, and need not exercise our discretion in the same way as the Department in its underlying decision. *Department of Soc. Servs. v. Mellas*, 220 S.W.3d 778 (Mo. App. W.D. 2007). The Department's answer provides notice of the basis for disallowing claims and imposing sanctions. *Ballew v. Ainsworth*, 670 S.W.2d 94, 103 (Mo. App. E.D. 1984).

New Trails admits it submitted claims that erroneously stated residents were present in the 9th Street group home on seven days that they were not. The issue is whether it should be sanctioned for these incorrect submissions, and if so, what the sanction should be.

The Department asserts in its answer thirteen grounds under 13 CSR 70-3.030(3)(A) for which it is authorized to impose sanctions:

1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to MO HealthNet;

2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services or billing for higher level of service or increased number of units from those actually ordered or performed or both, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;

4. Failing to make available, and disclosing to the MO HealthNet agency of its authorized agents, all records relating to the services provided to MO HealthNet participants...Copies of records must be provided upon request of the MO HealthNet agency or its authorized agents, regardless of the media in which they are kept. Failure to make these records available on a timely basis at the same site at which services were rendered...shall constitute a violation of this section and shall be a reason for sanction...Failure to send records, which have been requested via mail, within the specified time frame shall constitute a violation of this section and shall be a reason for sanction;

5. Failing to provide quality, necessary, and appropriate services, including adequate staffing for long-term care facility MO HealthNet participants, within accepted medical community standards...

6. Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of participants' personal funds or other funds;

7. Breaching of the terms of the MO HealthNet provider agreement of any current written and published policies and procedures of the MO HealthNet program (Such policies and procedures are contained in provider manuals or bulletins which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website www.dss.mo.gov/mhd, September 15, 2009. This rule does not incorporate any subsequent amendments or additions.) or failing to comply with the terms of the provider certification on the MO HealthNet claim form;

28. Billing for services through an agent, which were upgraded from those actually ordered, performed; or billing or coding services, either directly or through an agent, in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and

should have been billed or coded as integral components of a total service as prescribed in MO HealthNet policy for payment in a total payment less than the aggregate of the improperly separated services; or billing a higher level of service than is documented in the patient/client record; or unbundling procedure codes;

* * *

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication, or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. For providers other than long term care facilities, failing to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, [etc.]...;

* * *

37. Failure to comply with the provisions of the Missouri Department of Social Services, MO HealthNet Division Title XIX Participation Agreement with the provider relating to health care services;

38. Failure to maintain documentation which is to be made contemporaneously to the date of service;

39. Failure to maintain records for services provided and all billing done under his/her provider number regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim or both;

40. Failure to submit proper diagnosis codes, procedure codes, billing codes regardless to whom the reimbursement is paid and regardless of whom in his/her employ or service produced or submitted the MO HealthNet claim;

41. Failure to submit and document, as defined in subsection (2)(A) the length of time (begin and end clock time) actually spent providing a service, except for services as specified under 13 CSR 70-91.010(4)(A) Personal Care Program[.]

Analysis

New Trails bases its argument on § 5.3.2 of the DMH agreement. It argues that, despite submitting electronic attendance records for three of its group home residents that indicated they were present at the facilities on days they were actually away visiting family members, these

errors did not result in overbilling of MO HealthNet or in any windfall to New Trails because the ultimate reimbursement amount remains constant for each resident for each month of residency. In response, the Department argues the electronic attendance submissions were still false submissions to the Department made in violation of state regulations. It also argues that no representative of DMH testified to the meaning of § 5.3.2 of the DMH agreement, and therefore that:

It is far less than clear from that language that a provider's "allowable monthly costs" are unaffected by days the participant is absent from the facility, or that those dates of absence would not result in a lower rate of reimbursement to the provider given the limitation of the "Medicaid maximum per diem amount."

Resp. Brief at 16.

The Department seems to suggest that New Trails, by relying merely on a contract provision, has not met its burden to establish the fact that its billing for dates of service that certain residents were not present at the 9th Street home did not result in its receiving a larger Medicaid reimbursement than it was entitled to. However, Smith also testified that residents' absences do not result in a reduction of New Trails' monthly Medicaid reimbursement amount, and the Department presented no rebuttal on this point. When we consider Smith's testimony along with the contract provision and the lack of any evidence to the contrary, we conclude that New Trails has established that it would have been paid the same amount for the months at issue for those residents, even if it had properly reported their attendance.

This conclusion does not mean that submitting incorrect information to MO HealthNet is unimportant in this case or any other. We agree with the Department that provider responsibility to submit correct information is crucial to the integrity of the Medicaid program. With that observation in mind, we turn now to whether or not New Trails violated one or more of the

thirteen provisions of 13 CSR 70-3.030(3)(A) for which sanctions may be imposed. We address each in turn:

1. Presenting for payment any false or fraudulent claim for service in the course of business related to MO HealthNet. Because the regulation does not define the term “false,” we turn to the dictionary to determine the plain meaning of the word. See *E&B Granite, Inc. v. Dir. of Revenue*, 331 S.W.3d 314, 318 (Mo. banc 2011) (Absent a statutory definition, the plain meaning of words used in a statute, as found in the dictionary, is typically relied on); *State ex rel. Evans v. Brown Builders Elec. Co., Inc.*, 254 S.W.3d 31, 35 (Mo. banc 2008) (statutes and regulations are interpreted according to the same rules). The word “false,” as found in the dictionary, means:

1 a : not corresponding to the truth or reality : not true :
ERRONEOUS, INCORRECT... **b :** intentionally untrue : LYING[.]

WEBSTER’S THIRD NEW INT’L DICTIONARY UNABRIDGED 819 (1986).

“Fraudulent” is the adjective form of the noun “fraud,” defined in § 208.164 as “a known false representation . . . upon which the provider claims reimbursement under the terms and conditions of a contract or provider agreement and the policies pertaining to such contract or provider agreement[.]”

The meanings of “false” and “fraudulent” overlap, inasmuch as the former may include intent, and the latter must. However, we should endeavor to give every word in the regulation meaning and to avoid an interpretation that would render a word “mere surplusage.” *Langston v. Mo. Bd. of Probation and Parole*, 391 S.W.3d 473, 475 (Mo. App. W.D. 2012); *Evans*, 254 S.W.3d at 35. We therefore do not construe the word “false,” as used in the regulation, to include the component of intent. To do so would essentially equate the word to fraud, and render

“false” mere surplusage. *See Indep. Living Center of Mid Mo Inc. v. Dep’t of Social Services, MO HealthNet Div.*, 391 S.W.3d 52, 57 (Mo. App. W.D., 2013) (containing a similar discussion of “false” and “fraudulent” in *dicta*).²

In New Trails’ complaint, Smith stated:

When billing in CIMOR[³] the Provider unchecks the days the consumer is out of the home and the daily rate is then adjusted up to pay the Provider the same each month . . .

I believe Error A means that when I billed in CIMOR I must have not unchecked the above dates. I am usually very careful to make sure that I do this correctly. I am surprised that I did that during Christmas when I know the above consumers would have been going home. I could have been in a hurry and didn’t do it.

New Trails would not have been overpaid since the monthly payment is the same, but there must be a mistake in the way I billed. I apologize for my mistake.

This explanation, that the incorrect billing was the result of a mistake rather than a scheme to defraud the Medicaid program, is credible. We conclude New Trails’ submission of daily census data for group home residents that indicated they were present for residential care on individual days they were absent from the facility on family visits constituted the presentation of false, but not fraudulent, claims for payment. There is cause to sanction New Trails under 13 CSR 70-3.030(3)(A)1.

² In *Indep. Living Center*, the court in its *dicta* discussion saw no “obvious connection” between 13 CSR 70-3.030(A) and § 208.164, because the regulation was promulgated under the authority of §§ 208.153 and 208.201. We conclude there is a connection, however. Section 208.153 mandates that the predecessor to MO HealthNet promulgate rules to “define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided,” and specifies that persons entitled to medical assistance may obtain it “from any provider of services with which an agreement is in effect under this section and which undertakes to provide the services, as authorized by the division of medical services.” Section 208.164 defines “medical assistance benefits,” “provider,” and “service,” and provides that the “department or its divisions shall have the authority to suspend, revoke, or cancel any contract or provider agreement” when it determines a provider has committed acts defined as abuse or fraud in this section. The two statutes are *in pari materia* and we therefore find § 208.164’s definition applicable herein. *See Frye v. Levy*, 2014 WL 3107299, *16 (Mo. banc, 2014).

³ “CIMOR” is not defined in the record, but from other testimony we infer that it is the software program providers use to bill the Medicaid program for residential habilitation services.

2. Submitting false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable MO HealthNet program policies or rules.

See # 1, above. While we have found that New Trails submitted false information, it did not do so to obtain greater compensation than that to which it was entitled. We find no cause for sanction under this paragraph.

4. Failing to make all records relating to services available on request and on a timely basis. There is no evidence that New Trails failed to make any of the 9th Street home records timely available upon request. There is no cause for sanction under this paragraph.

5. Failing to maintain quality, necessary and appropriate services within accepted medical community standards. There was no evidence presented that such failures existed in provision of services to New Trails residents.

6. Engaging in conduct or performing an act deemed improper or abusive of the MO HealthNet program. Because the regulation does not define the term “improper,” we again turn to the dictionary to determine the plain meaning of the word. “Improper” means “not proper: as **a** : not in accord with fact, truth, or right procedure : INCORRECT.” WEBSTER'S, *id.*, at 1137. “Abusive” is the adjective derived from the noun “abuse,” which is defined under § 208.164(1) as:

a documented pattern of inducing, furnishing, or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered.

New Trails submitted inaccurate claims to MO HealthNet indicating that residents were present on days they were not. This conduct does not meet the statutory definition of abusive, but it was

not in accord with the right procedure and was thus improper. It is a basis for sanction under Regulation 13 CSR 70-3.030(3)(A)6.

7. Breaching of the terms of the MO HealthNet provider agreement or any current written and published policies and procedures of the MO HealthNet program. New Trails breached its provider agreement by submitting false claims to MO HealthNet and thereby violating Medicaid regulations. There is cause to sanction it under 13 CSR 70-3.030(3)(A)7.

28. Billing for upgraded services or a higher level of service than that which was provided. We were provided no evidence of such misconduct on the part of New Trails and find no basis for sanctions under this provision.

31. Failing to take reasonable measures to review claims for payment for accuracy, or other errors when the failure allows material errors in billing to occur. We infer from its complaint that New Trails failed to take reasonable measures to review the claims at issue for accuracy. And, even though we have found that the inaccuracy resulted in no financial harm to the Medicaid program, it is of critical importance that providers not submit inaccurate information to the Department. Thus, we also find that the errors in question were “material” as defined by the dictionary: “being of real importance or great consequence.” WEBSTER’S, *id.*, at 1392. There is cause to sanction New Trails under 13 CSR 70-3.030(3)(A)31.

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider. New Trails submitted false claims to the MO HealthNet program through its owner and administrator, Rick Smith. There is cause to sanction it under 13 CSR 70-3.030(3)(A)32.

33. Failing to retain documents for a requisite number of years. There is no evidence in this case that New Trails failed to maintain required documentation.

37. Failure to comply with the provisions of the Missouri Department of Social Services, MO HealthNet Division Title XIX Participation Agreement with the provider relating to health care services. There is no evidence that New Trails failed to comply with any provision of its participation agreement that related to health care services.

38. Failure to maintain documentation which is to be made contemporaneously to the date of service. We find no evidence of such a deficiency.

39. Failure to maintain records of services provided and billing done under his/her provider number. We find no evidence of such a deficiency.

40. Failure to submit proper diagnosis codes, procedure codes, or billing codes. We find no evidence of such a deficiency.

41. Failure to submit and document start and end clock times for services. We find no evidence of such a deficiency. Moreover, there is no explanation in the record as to why such information would be required for the type of services provided to developmentally disabled residents of group homes. We find no cause to sanction New Trails under this paragraph.

Summary of Cause

There is cause to sanction New Trails under 13 CSR 70-3.030(3)(A)1, 6, 7, 31, and 32.

Sanctions

Regulation 13 CSR 70-3.030(4) provides:

Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (3) of this rule:

* * *

(B) Termination from participation in the MO HealthNet program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the MO HealthNet program for a specified period of time;

- (D) Suspension or withholding of payments to a provider;
- (E) Referral to peer review committees including PSROs or utilization review committees;
- (F) Recoupment from future provider payments;
- (G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;
- (H) Attendance at provider education sessions;
- (I) Prior authorization of services;
- (J) One hundred percent (100%) review of the provider's claims prior to payment;
- (K) Referral to the state licensing board for investigation;
- (L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;
- (M) Retroactive denial of payments[.]

The Department argues that the appropriate sanction is retroactive denial of payments for services, and recoupment of those amounts. New Trails argues that no sanction should be imposed because its offense was not serious or extensive, and did not result in financial loss to the Medicaid program.

Under 13 CSR 70-3.030(5)(A), the imposition of a sanction is discretionary. The filing of the appeal vests the Department's discretion in this Commission, but we are not required to exercise it in the same way the Department did. *Mellas*, 220 S.W.3d at 782-83. Regulation 13 CSR 70-3.030(5)(A) provides guidance for the exercise of that discretion:

The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s)—The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to MO HealthNet participants, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous

medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;

2. Extent of violations—The state MO HealthNet agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of MO HealthNet claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred;

3. History of prior violations—The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of sanctions—The MO HealthNet agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the MO HealthNet program, any other governmental medical program, Medicare, or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection; [and]

5. Prior provision of provider education—In cases where sanctions are being considered for billing deficiencies only, the MO HealthNet agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions[.]

We address the five factors in turn:

1. Seriousness of the offense—There is no evidence in this case of substandard services or inadequate care to the residents of the 9th Street home. And there was technically no overpayment, as that term is defined as “an amount of money paid to a provider by the Medicaid agency to which s/he was not entitled by reason of improper billing, error, fraud, abuse, lack of verification, or insufficient medical necessity[.]” 13 CSR 70-3.130(E).

By the regulation's terms, however, we are not limited to considering those factors. It is self-evident that the integrity of the Medicaid program relies on the accuracy of the information that providers submit. Even under circumstances in which the program suffered no financial harm, we consider the submission of false information to be a very serious breach of the rules.

2. Extent of Violations. New Trails, in its written argument, characterizes the violations as not extensive because “the \$1,226.04 in question is 3.2% of the total billing. The seven days in question are 2.5% of the 276 billing days for the three clients.” Pet Post-hearing brief at 3. We have no reason to question its figures. We find the violations are not extensive, but neither are they *de minimis*.

3. History of Prior Violations—We were presented with no evidence of prior violations in New Trails' history.

4. Prior Imposition of Sanctions—The record is devoid of any reference to the previous imposition of sanctions on New Trails.

5. Prior Provision of Provider Education—Sanctions may be mitigated if the Department did not give the provider appropriate education. 13 CSR 70-3.030(5)(A)5. If it did, a more severe sanction may be appropriate if the same deficiencies were repeated. *Id.* There is no evidence in the record concerning provider education given to New Trails, and we therefore infer that New Trails has not been subject to provider retraining, so some leeway could have been properly afforded under the circumstances.

Conclusion as to Sanctions

New Trails did not intend to defraud the Medicaid program, but on several occasions it submitted false information with its claims during the audit period. Although these regulatory violations resulted in no financial harm to the Department, they are of the type that can undermine the integrity of the State's Medicaid program, and providers must take all necessary

steps to prevent them from occurring. We exercise our discretion in the same manner as the Department, and impose the sanction of full recoupment.

Summary

New Trails is subject to the sanction of recoupment in the amount of \$1,226.04.

SO ORDERED on August 21, 2014.

/s/ Karen A. Winn

KAREN A. WINN
Commissioner